MISSOURI COMMISSION ON PATIENT SAFETY
MEETING MINUTES
March 17, 2004
10:00 a.m. – 4:00 p.m.
Capitol Plaza
Jefferson City, Missouri

OFFICIAL

Commissioners in attendance: Gregg Laiben, James Buchanan, Thomas Cartmell, Deborah Jantsch, Susan Kendig, Kathryn Nelson, Bea Roam, Stephen Smith, James Utley, Kenneth Vuylsteke, and Tina Steinman, Lori Scheidt, Kevin Kinkade, Alan Morris, William Schoenhard, Barry Spoon.

I. CALL TO ORDER
Dr. Gregg Laiben, Chairperson
The meeting was called to order at 10:10 AM. Silent roll call was taken.

Review of Draft Minutes from the previous meeting saved for the afternoon.

Housekeeping items:

Linda Bohrer reviewed today's handouts. She and MDI staff have created compilations of information related to the four subcommittees created at the last two meetings. Those committees are:

- Patient Safety Center
- Education for providers and patients
- Protection of error/near miss information and expansion of the peer review protections
- Data collection and reporting

For each subcommittee topic, information was compiled from the following sources:

- Recommendations and important statements made by various commissioners at previous meetings
- Recommendations and important statements made by various presenters at previous meetings
- Handouts from previous meetings, specifically recommendations and important statements
- The statements made by each commissioner at the very first meeting regarding their vision of the Commission's goals.

In addition, a packet was compiled from the same sources for any items that didn't seem to fit into the four subcommittee categories.

Subcommittees were encouraged to use these packets of information to assure that important items were not forgotten or minimized.

II. SUBCOMMITTEE'S WORKING MORNING

Subcommittees worked independently through the morning. Subcommittee membership:

Patient Safety Center
Dr. Laiben
Kathryn Nelson
William Schoenhard
Scott Lakin

Education
Susan Kendig
Dr. Morris
Dr. Buchanan
Tina Steinman

Protection/peer review
Thomas Cartmell
Kenneth Vuylsteke
Dr. Utley
Dr. Spoon
Kevin Kinkade
Lois Kollmeyer

Data collection and reporting
Dr. Smith
Dr. Jantz
Bea Roam
Lori Scheidt
Nancy Kimmel

Each subcommittee worked at their own table and had access to computers, printers and office supplies. MDI staff was on hand to assist with making copies or running other necessary errands, at the direction of the subcommittees.

The subcommittees stopped for lunch between 12:15 and 1:15 PM.

III. REVIEW AND APPROVAL OF DRAFT MINUTES FROM PREVIOUS MEETING

Kathryn Nelson had a few suggestions for changes. Dr. Laiben asked for approval of the minutes as amended. Minutes were approved as amended on a voice vote and there were no objections.

IV. BRIEF REPORT FROM EACH SUBCOMMITTEE

After lunch, each subcommittee reported on their morning efforts to the entire Commission.

Protection/peer review

- This group focused today on defining the problem. They had produced an outline and a flow chart for where protection was needed in the discussion of medical errors. (Attached)
- A key problem was what to do with Missouri's current peer review statute. The subcommittee wants to recommend changes because the current statute is:
    - Too limiting in terms of participants
    - Doesn't recognize the modern business of healthcare, for example, risk managers are not protected
    - Inefficient
- The limitation to licensed medical professionals only should be eliminated, or the list of licensed providers should be much broader.
- Quality improvement/risk management activities should be protected to encourage rapid and thorough investigations
- The goal is to encourage education of quality/safety outliers by sharing information freely
- New Jersey had proposed revision of their peer review law, and had included a statement of need and intent. The subcommittee would like to see something similar happen in Missouri.
- Reporting of errors to a centralized statewide safety entity should be mandatory, and disclosing errors to patients should also be mandatory.
- Information shared between healthcare entities and the safety entity should be encouraged through protection.
- There should be better enforcement of the law requiring healthcare entities to report disciplinary activities. In addition, the requirement to report such activities should be expanded to all health care entities. Currently only hospitals and ambulatory surgical centers are required to report disciplinary activity to the state Boards.

Patient Safety Center (original draft recommendation attached, without edits from this meeting)

This group was able to build on the information and outline provided at the previous meeting. In addition to the information previously presented, the group discussed the following:

- The results of root cause analysis should be reported to the Center. Reports should be anonymous.
- The Center should disseminate this information gleaned from such reporting in the form of alerts or bulletins that facilities can readily adopt.
- Reporting of an event isn't where learning lies. Learning occurs through the RCA process, and the solutions arrived at through this process. Therefore, the Center would not seem to need event reporting (such as the sentinel events reported to JCAHO), just reports of solutions and processes.
- The Veterans Administration makes reporting part of the RCA process. Since all system institutions report, the VA can aggregate and learn from this reporting.

Dr. Utley suggested maintaining a profile of each reporting entity to monitor over time if the entity is effectively using and learning from the RCA process.

- The Center should be independent and not-for-profit. The governing board should consist of key stakeholders.
- The Center could serve as a resource for providers, particularly those providers that may not have the resources to engage in their own RCA. The Center could have expert staff available to perform RCA on behalf of such entities, or consult with them.
- The subcommittee is leaning towards asking for seed money from government or key stakeholders to fund the first year or so of operations. Once established, it would be the Center's responsibility to figure out how to keep itself going. Options include applying for grants, soliciting support from the business community and from stakeholders, membership dues or fees for services.
- Participation with the Center should be mandatory for medical providers. The government could play an important role by requiring Medicaid and MCHCP contractors to participate as a condition of contracting.

Q: What other ideas do you have for encouraging participation through "tying" arrangements? For physicians, Medicaid contracts are not a big enough inducement.
A: Agreed. Hospitals would respond to Medicaid pressure, but practitioners would not. For practitioners, participation could be tied to licensure or continuing professional education.

- The subcommittee is sensitive to the problem of overburdening providers with too much reporting.
- No provider should have to report without a clear idea of what the information will be used for.

Q: How will the Center disseminate information?
A: The VA seems to offer a good model, with dissemination through bulletins and alerts, and through offering a technical hotline. In fact, the University of Missouri-Columbia

Hospital has used the VA's technical hotline. VA tools are available on the Internet for no charge.

- The Center could conduct focused research. For example, the VA studied which brand of surgical sponges show up the best on X-rays. Grants are available for research activities.

- Commissioners may be asked to contact professional or business associations they are connected with to see if there is support and commitment to the ideas the Commission has come up with. This will serve as kind of a reality check to see if a different approach should be taken. The final recommendation may include comments about any support the Commission is able to establish with key stakeholders.

Bill Schoenhard indicated that the Hospital Association is willing to help support and fund a Patient Safety Center. Dr. Laiben indicated the same for MissouriPRO.

Q: How much money does the Commission have in mind?
A: Don't know. Feel the amount is not as critical as commitment in terms of launching the Center. The operating budgets for other state Centers seems to be $1 to $3 million per year.

Dr. Jantz suggested that the proposed Center should have a business plan in mind when soliciting for financial support. Linda Bohrer will work with MHA (Becky Miller) and MoPro (Ila Irwin) to develop a draft business plan for a proposed Patient Safety Center for the next commission meeting.

- The Center should not be a government agency. There is a role for government, and the subcommittee is working to figure out that role.

Q: How do non-hospital facilities fit in?
A: That's in discussion. A possible model would be the agricultural extension agents model. There's no clear answer yet.

- The Center's leadership should include one or two "at large" positions. Health care workers should be included.

<u>Data collection and reporting</u>: (working documents attached)

- Some institutions may distrust a state-wide agency looking over their shoulders. This subcommittee tried to focus on the data collection and reporting that occurs within an institution.
- Data collection and reporting should build on existing incident reports.
- Reporting of near-misses should be encouraged and solicited from front-line workers
- Workers should be protected from sanctions.

- People should be assured that reports will be used and acted upon in a non-retaliatory manner.
- Facilities should have a Patient Safety Officer (PSO) with training in RCA.
- Reports should go to the Center periodically, such as once a year, rather than constantly as events occur.
- Control of the data may need to be retained by the institution.
- Reports should be de-identified. Institutions have to overcome too much fear of litigation. Even if the law were changed, the fear persists.
- The subcommittee is struggling with the idea of encouraging a practitioner to volunteer information on errors by use of possible incentives.
- Having the error reporting stay at the institutional level helps defray costs to the state, gets the institutions to perform the critical work of analysis and assessment, and offers immediate closure for the practitioner.

Suggestion: The size of the institution may be a "means test" for whether or not the institution can perform its own analysis, or if the Center should do it.

- Standardization is important. Each institution's PSO should use a standardized reporting form to report to the Center.
- The state may want to develop a standard job description for the PSO.

Q: Does the PSO have to be a separate position, or could one person hold that title in addition to other titles?
A: It doesn't have to be one person's dedicated position. Part of the goal is not to create more work, but to coordinate existing work to improve safety.

- The medical community would be more receptive to reporting requirements if reports were de-identified. This word may replace either "mandatory" or "voluntary".
- The subcommittee felt that there must be some kind of incentive for institutions to report to the Center. If the Center could provide recognition for reducing errors, medical malpractice carriers may be more likely to give a discount on premiums.

Dr. Utley suggested that the managed care industry would view recognition favorably if it were shown to reduce illness and therefore costs. There are consultants available that can help establish this proof. Selling safety as a public relations issue will increase buy-in. Encourage participation with reimbursement or managed care contracting.

Dr. Jantz suggested that the issue of return on investment should be addressed. Providers and physicians are already doing lots of reporting. Tools for providers would distinguish patient safety from all the other required reporting. Providers would see the tools as a reasonable return on the investment required to do additional reporting.

- De-identifying data may detract from the ability to use safety data for public relations. The subcommittee considered recommending that each reporting entity could chose whether or not to identify themselves.

- Data collection should not ignore the non-medical issues, the systems issues.

The Commission took a short break at 2:30 and returned at 2:50.

Education

Susan Kendig, the chairperson for this committee, had provided a working document in advance, and the subcommittee built upon this. The document was based on a literature review and the testimony of presenters. (Attached)

- Education across professions on patient safety is important.
- The Center plays a role as curriculum repository and continuing education repository by collecting and making available safety information and best practices.
- The subcommittee took a broad definition of "health professional", using an interdisciplinary model.
- Educational recommendations should avoid discreet courses. Integrate patient safety throughout education and career.
- Core concepts were identified.
- It was noted that some medical malpractice cases deal with student supervision problems.
- Some potential barriers to educational goals might be funding, time, and faculty resistance to change.
- Safety should be integrated into competency reviews.
- Patient safety should be tied to licensure renewal and continuing education. It was noted that nursing has no continuing education requirements.
- Continuing education can be interdisciplinary, developed by all the professional boards together.
- Patient safety could be tied to inter-state licensure reciprocity.
- For consumers, education should focus on empowerment. The consumer/patient should be able to ask access information about their provider's experience.

Q: You mentioned raising the licensure fees. Why?
A: To help fund the educational goals of the Center, develop continuing education programs, etc.

V. CONCLUDING DISCUSSION

Linda Bohrer announced that the next meeting will be April 7th. There will be one presenter in the afternoon. The rest of the day will be set aside to continue work on the final recommendations.

Dr. Laiben asked if there should be any additional subcommittees. Dr. Jantz suggested a group to develop a business plan to approach stakeholders. Linda Bohrer, Ila Irwin (MoPro) and Becky Miller (MHA) will work on this.

Q: What should be prepared for next week?

A: Dr. Laiben asked Commissioners to strive to have something in writing for each subcommittee that resembled the draft Patient Safety Center created by MDI staff. It doesn't need to be very long. It should include a problem statement and recommendations. **Recommendations should tie to the testimony heard.** MDI staff can work on fleshing out the rationale, based on the information presented to the Commission. Anyone feeling especially ambitious could draft a paragraph or two on background information, review of applicable testimony or outside literature.

Groups returned to their tables for further work before the end of the day.

There were no public comments. The meeting adjourned at 4:10 PM.